Health, Welfare Public Service

. 300
. 1-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

FILED OCT 21 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

37707

Registration District No. 318 Primary Registration District No. 1003 STATE FILE NUMBER 9378 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri	b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St.Louis Mo.	Inside Limits Yes X No	c. CITY OR TOWN St.Louis	Inside Limits Yes X No
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 0/ 1917 Montgomery Str.	Length of stay in 1b 26	d. STREET ADDRESS (If outside, give location) 1917 Montgomery Str.	Reside on Farm Yes X No

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	MRS. JOY	M	KOCHMANN		Oct.	7	1957

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	X	Mar. 19. 1923	34		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		St.Louis Mo.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Edward Schulze	Helen Walters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
no			Frank Kochmann, husband	.1917 Montgomery

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Apoplexy — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

334X

19. WAS AUTOPSY PERFORMED? YES X NO

20a. ACCIDENT	SUICIDE	HOMICIDE	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY	Hour	Month, Day, Year
	a. m. / p. m.	

20d. INJURY OCCURRED	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
WHILE AT WORK / NOT WHILE AT WORK				

21. I attended the deceased from _____ to _____ and last saw her / him alive on _____

Death occurred at 2:30A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
Patrick L. Taylor Coroner	1300 Clark	10-8-57.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Removal	Oct. 10. 1957	Memorial Park Cemetery	St. Louis County Mo.

24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Hy. Leidner Und. Co. 2223 St. Louis Ave.	OCT 8 '57	Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....Albert Mayfield

Licensed Embalmer No. 30

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
to comply with the above constitutes grounds for revocation of license):

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.